House of Representatives

General Assembly

File No. 439

February Session, 2012

Substitute House Bill No. 5321

House of Representatives, April 16, 2012

The Committee on Public Health reported through REP. RITTER, E. of the 38th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING THE OFFICE OF HEALTH CARE ACCESS AND NOTICE BY HEALTH CARE FACILITIES REGARDING CONTRACTS FOR SERVICES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (a) of section 19a-639 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2012*):

(a) In any deliberations involving a certificate of need application filed pursuant to section 19a-638, the office shall take into consideration and make written findings concerning each of the following guidelines and principles:

(1) Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the **[**office**]** Department of Public Health;

(2) The relationship of the proposed project to the state-wide health care facilities and services plan;

(3) Whether there is a clear public need for the health care facility or services proposed by the applicant;

(4) Whether the applicant has satisfactorily demonstrated **[**how the proposal will impact the financial strength of the health care system in the state**]** that the proposal is financially feasible for the applicant;

(5) Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region;

(6) The applicant's past and proposed provision of health care services to relevant patient populations and payer mix;

(7) Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;

(8) The utilization of existing health care facilities and health care services in the service area of the applicant; and

(9) Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities.

Sec. 2. Subsections (a) to (d), inclusive, of section 19a-639a of the 2012 supplement to the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2012*):

(a) An application for a certificate of need shall be filed with the office in accordance with the provisions of this section and any regulations adopted by the **[**office**]** Department of Public Health. The application shall address the guidelines and principles set forth in (1) subsection (a) of section 19a-639, and (2) regulations adopted by the **[**office**]** department. The applicant shall include with the application a nonrefundable application fee of five hundred dollars.

(b) Prior to the filing of a certificate of need application, the

applicant shall publish notice that an application is to be submitted to the office in a newspaper having a substantial circulation in the area where the project is to be located. Such notice shall (1) be published (A) not later than twenty days prior to the date of filing of the certificate of need application, and (B) for not less than three consecutive days, and (2) contain a brief description of the nature of the project and the street address where the project is to be located. An applicant shall file the certificate of need application with the office not later than ninety days after publishing notice of the application in accordance with the provisions of this subsection. The office shall not accept the applicant's certificate of need application for filing unless the application is accompanied by the application fee prescribed in subsection (a) of this section and proof of compliance with the publication requirements prescribed in this subsection.

(c) Not later than five business days after receipt of a properly filed certificate of need application, the office shall publish notice of the application on its web site. Not later than thirty days after the date of filing of the application, the office may request such additional information as the office determines necessary to complete the application. The applicant shall, not later than sixty days after the date of the office's request, submit the requested information to the office. If an applicant fails to submit the requested information to the office within the sixty-day period, the office shall consider the application to have been withdrawn.

(d) Upon determining that an application is complete, the office shall provide notice of this determination to the applicant and to the public in accordance with regulations adopted by the **[**office**]** department. In addition, the office shall post such notice on its web site. The date on which the office posts such notice on its web site shall begin the review period. Except as provided in this subsection, (1) the review period for a completed application shall be ninety days from the date on which the office posts such notice on its web site; and (2) the office shall issue a decision on a completed application prior to the expiration of the ninety-day review period. Upon request or for good

cause shown, the office may extend the review period for a period of time not to exceed sixty days. If the review period is extended, the office shall issue a decision on the completed application prior to the expiration of the extended review period. If the office holds a public hearing concerning a completed application in accordance with subsection (e) or (f) of this section, the office shall issue a decision on the completed application not later than sixty days after the date **[**of**]** the office closes the public hearing record.

Sec. 3. Section 19a-644 of the general statutes is amended by adding subsection (e) as follows (*Effective October 1, 2012*):

(NEW) (e) Each short-term acute care general or children's hospital shall report to the office with respect to operational and utilization data on a quarterly basis, in such form as the Department of Public Health may by regulation require. Reports that include such data from the prior quarter shall be submitted to the office on or before: (1) January thirty-first; (2) April thirtieth; (3) July thirty-first; and (4) October thirty-first.

Sec. 4. Subsection (a) of section 19a-649 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2012*):

(a) The office shall review annually the level of uncompensated care provided by each hospital to the indigent. Each hospital shall file annually with the office its policies regarding the provision of charity care and reduced cost services to the indigent, excluding medical assistance recipients, and its debt collection practices. A hospital shall file its audited financial statements **[**by**]** not later than February twenty-eighth of each year. **[**The filing shall include**]** Not later than March thirty-first of each year, the hospital shall file a verification of the hospital's net revenue for the most recently completed fiscal year in a format prescribed by the office.

Sec. 5. Section 19a-7e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2012*):

The Department of Public Health, in consultation with the Department of Social Services, shall establish a three-year demonstration program to improve access to health care for uninsured pregnant women under two hundred fifty per cent of the poverty level. Services to be covered by the program shall include, but not be limited to, the professional services of obstetricians, dental care providers, physician assistants or midwives on the staff of the sponsoring hospital and community-based providers; services of pediatricians for purposes of assistance in delivery and postnatal care; dietary counseling; dental care; substance abuse counseling, and other ancillary services which may include substance abuse treatment and mental health services, as required by the patient's condition, history or circumstances; necessary pharmaceutical and other durable medical equipment during the prenatal period; and postnatal care, as well as preventative and primary care for children up to age six in families in the eligible income level. The program shall encourage the acquisition, sponsorship and extension of existing outreach activities and the activities of mobile, satellite and other outreach units. The Commissioner of Public Health shall issue a request for proposals to Connecticut hospitals. Such request shall require: (1) An interactive relationship between the hospital, community health centers, community-based providers and the healthy start program; (2) provisions for case management; (3) provisions for financial eligibility screening, referrals and enrollment assistance where appropriate to the medical assistance program, the healthy start program or private insurance; and (4) provisions for a formal liaison function between hospitals, community health centers and other health care providers. **[**The Office of Health Care Access is authorized, through the hospital rate setting process, to fund specific additions to fiscal years 1992 to 1994, inclusive, budgets for hospitals chosen for participation in the program. In requesting additions to their budgets, each hospital shall address specific program elements including adjustments to the hospital's expense base, as well as adjustments to its revenues, in a manner which will produce income sufficient to offset the adjustment in expenses. The office shall insure that the network of hospital

providers will serve the greatest number of people, while not exceeding a state-wide cost increase of three million dollars per year.**]** Hospitals participating in the program shall report monthly to the Departments of Public Health and Social Services or their designees and annually to the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services such information as the departments and the committees deem necessary.

Sec. 6. Subsections (a) and (b) of section 19a-634 of the 2012 supplement to the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2012*):

(a) The Office of Health Care Access shall conduct, on **[**an annual**]** a biennial basis, a state-wide health care facility utilization study. Such study **[**shall**]** may include **[**, but not be limited to,**]** an assessment of: (1) Current availability and utilization of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) geographic areas and subpopulations that may be underserved or have reduced access to specific types of health care services; and (3) other factors that the office deems pertinent to health care facility utilization. Not later than June thirtieth of **[**each**]** the year in which the biennial study is conducted, the Commissioner of Public Health shall report, in accordance with section 11-4a, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services on the findings of the study. Such report may also include the office's recommendations for addressing identified gaps in the provision of health care services and recommendations concerning a lack of access to health care services.

(b) The office, in consultation with such other state agencies as the Commissioner of Public Health deems appropriate, shall establish and maintain a state-wide health care facilities and services plan. Such plan may include, but not be limited to: (1) An assessment of the availability of acute hospital care, hospital emergency care, specialty hospital care,

outpatient surgical care, primary care and clinic care; (2) an evaluation of the unmet needs of persons at risk and vulnerable populations as determined by the commissioner; (3) a projection of future demand for health care services and the impact that technology may have on the demand, capacity or need for such services; and (4) recommendations for the expansion, reduction or modification of health care facilities or services. In the development of the plan, the office shall consider the recommendations of any advisory bodies which may be established by the commissioner. The commissioner may also incorporate the recommendations of authoritative organizations whose mission is to promote policies based on best practices or evidence-based research. The commissioner, in consultation with hospital representatives, shall develop a process that encourages hospitals to incorporate the state-wide health care facilities and services plan into hospital long-range planning and shall facilitate communication between appropriate state agencies concerning innovations or changes that may affect future health planning. The office shall update the state-wide health care facilities and services plan **[**on or before July 1, 2012, and every five years thereafter**]** not less than once every two years.

Sec. 7. Subsections (a) to (g), inclusive, of section 19a-646 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2012*):

(a) As used in this section:

(1) "Office" means the Office of Health Care Access division of the Department of Public Health;

(2) "Fiscal year" means the hospital fiscal year, as used for purposes of this chapter, consisting of a twelve-month period commencing on October first and ending the following September thirtieth;

(3) "Hospital" means any short-term acute care general or children's hospital licensed by the Department of Public Health, including the John Dempsey Hospital of The University of Connecticut Health Center;

(4) "Payer" means any person, legal entity, governmental body or eligible organization that meets the definition of an eligible organization under 42 USC Section 1395mm (b) of the Social Security Act, or any combination thereof, except for Medicare and Medicaid which is or may become legally responsible, in whole or in part for the payment of services rendered to or on behalf of a patient by a hospital. Payer also includes any legal entity whose membership includes one or more payers and any third-party payer; and

(5) "Prompt payment" means payment made for services to a hospital by mail or other means on or before the tenth business day after receipt of the bill by the payer.

(b) No hospital shall provide a discount or different rate or method of reimbursement from the filed rates or charges to any payer except as provided in this section.

[(c) (1) From April 1, 1994, to June 30, 2002, any payer may directly negotiate for a different rate and method of reimbursement with a hospital provided the charges and payments for the payer are reported in accordance with this subsection. No discount agreement or agreement for a different rate or method of reimbursement shall be effective until filed with the office.**]**

[(2) On and after July 1, 2002, any**]** (c) (1) Any payer may directly negotiate with a hospital for a different rate or method of reimbursement, or both, provided the charges and payments for the payer are on file at the hospital business office in accordance with this subsection. No discount agreement or agreement for a different rate or method of reimbursement, or both, shall be effective until a complete written agreement between the hospital and the payer is on file at the hospital. Each such agreement shall be available to the office for inspection or submission to the office upon request, for at least three years after the close of the applicable fiscal year.

[(3) On and after April 1, 1994, the**]** (2) The charges and payments for each payer receiving a discount shall be accumulated by the

hospital for each payer and reported as required by the office. **[**The office may require a review by the hospital's independent auditor, at the hospital's expense, to determine compliance with this subsection.

(4) From October 2, 1991, to June 30, 2002, a full written copy of each agreement executed pursuant to this subsection shall be filed with the Office of Health Care Access by each hospital executing such an agreement, no later than ten business days after such agreement is executed. On and after July 1, 2002, a**]**

(3) A full written copy of each agreement executed pursuant to this subsection shall be on file in the hospital business office within twenty-four hours of execution. **[**Each agreement filed shall specify on its face that it was executed and filed pursuant to this subsection. Agreements filed at the Office of Health Care Access, in accordance with this subsection, shall be considered trade secrets pursuant to subdivision (5) of subsection (b) of section 1-210, except that the office may utilize and distribute data derived from such agreements, including the names of the parties to the agreement, the duration and dates of the agreement and the estimated value of any discount or alternate rate of payment.**]**

(d) A payer may negotiate with a hospital to obtain a discount on rates or charges for prompt payment.

(e) A payer may also negotiate for and may receive a discount for the provision of the following administrative services: (1) A system which permits the hospital to bill the payer through either a computer-processed or machine-readable or similar billing procedure; (2) a system which enables the hospital to verify coverage of a patient by the payer at the time the service is provided; and (3) a guarantee of payment within the scope of the agreement between the patient and the third-party payer for service to the patient prior to the provision of that service.

(f) No hospital may require a payer to negotiate for another element or any combination of the above elements of a discount, as established

in subsections (d) and (e) of this section, in order to negotiate for or obtain a discount for any single element. No hospital may require a payer to negotiate a discount for all patients covered by such payer in order to negotiate a discount for any patient or group of patients covered by such payer.

(g) Any hospital which agrees to provide a discount to a payer under subsection (d) or (e) of this section shall file a copy of the agreement in the hospital's business office and shall provide the same discount to any other payer who agrees to make prompt payment or provide administrative services similar to that contained in the agreement. Each agreement filed shall specify on its face that it was executed and filed pursuant to this subsection. **[**The office shall disallow any agreement which gives a discount pursuant to the terms of subsections (d) and (e) of this section which is in excess of the maximum amount set forth in said subsections. No such agreement shall be contingent on volume or drafted in such a manner as to limit the discount to one or more payers by establishing criteria unique to such payers. Any payer aggrieved under this subsection may petition the office for an order directing the hospital to provide a similar discount. The Department of Public Health shall adopt regulations in accordance with the provisions of chapter 54 to carry out the provisions of this subsection.**]**

Sec. 8. Section 19a-676 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2012*):

On or before March thirty-first of each year, for the preceding fiscal year, each hospital shall submit to the office, in the form and manner prescribed by the office, the data specified in regulations adopted by the commissioner in accordance with chapter 54, the **[**independent audit**]** hospital's verification of net revenue required under section 19a-649, as amended by this act, and any other data required by the office, including hospital budget system data for the hospital's twelve months' actual filing requirements.

Sec. 9. Subsection (d) of section 19a-654 of the 2012 supplement to

the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2012*):

(d) Except as **[**otherwise**]** provided in this subsection, patient-identifiable data received by the office shall be kept confidential and shall not be considered public records or files subject to disclosure under the Freedom of Information Act, as defined in section 1-200. The office may release de-identified patient data or aggregate patient data to the public in a manner consistent with the provisions of 45 CFR 164.514. Any de-identified patient data released by the office shall exclude provider, physician and payer organization names or codes and shall be kept confidential by the recipient. The office may **[**not**]** release patient-identifiable data **[**except**]** (1) as provided for in section 19a-25 and regulations adopted pursuant to **[**said**]** section 19a-25, and (2) to (A) a state agency for the purpose of improving health care service delivery, (B) a federal agency or the office of the Attorney General for the purpose of investigating hospital mergers and acquisitions, or (C) another state's health data collection agency with which the office has entered into a reciprocal data-sharing agreement for the purpose of certificate of need review or evaluation of health care services, upon receipt of a request from such agency, provided, prior to the release of such patient-identifiable data, such agency enters into a written agreement with the office pursuant to which such agency agrees to protect the confidentiality of such patient-identifiable data and not to use such patient-identifiable data as a basis for any decision concerning a patient. No individual or entity receiving patient-identifiable data may release such data in any manner that may result in an individual patient, physician, provider or payer being identified. The office shall impose a reasonable, cost-based fee for any patient data provided to a nongovernmental entity.

Sec. 10. (NEW) (*Effective October 1, 2012*) A health care facility, as defined in section 19a-630 of the general statutes, that enters, or intends to enter, into a contract for the provision of health care services with a corporation, limited liability company, organization, partnership, firm or association that is licensed or certified by the state

to provide health care services shall, not later than three business days after entering into such contract or twenty-one business days prior to the effective date of such contract, whichever occurs later: (1) Notify the Commissioner of Public Health in writing that it has entered, or intends to enter, into a contract for such services; and (2) publish notice that it has entered, or intends to enter, into a contract for such services in a conspicuous place on the health care facility's web site. Such notice shall include a description of the services to be provided pursuant to the terms of the contract. The provisions of this section shall not apply to a contract entered into between a health care facility and a licensed health care professional under which such health care professional provides services to the health care facility as an independent contractor.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2012*	19a-639(a)
Sec. 2	*October 1, 2012*	19a-639a(a) to (d)
Sec. 3	*October 1, 2012*	19a-644
Sec. 4	*October 1, 2012*	19a-649(a)
Sec. 5	*October 1, 2012*	19a-7e
Sec. 6	*October 1, 2012*	19a-634(a) and (b)
Sec. 7	*October 1, 2012*	19a-646(a) to (g)
Sec. 8	*October 1, 2012*	19a-676
Sec. 9	*October 1, 2012*	19a-654(d)
Sec. 10	*October 1, 2012*	New section

Statement of Legislative Commissioners:

In section 1(a)(1), "office" was changed to "**[**office**]** Department of Public Health", for accuracy; in section 2, subsections (a) to (d), inclusive, were added, in subsection (a) "office" was changed to "**[**office**]** Department of Public Health" and, in (a)(2) "office" was changed to "**[**office**]** department" and, in the first sentence of (d), "office" was changed to "**[**office**]** Department of Public Health", for accuracy; in the first sentence of section 3(e), "office" was changed to "Department of Public Health, for accuracy"; in the first sentence of section 10, ", or intends to enter," was inserted after "enters", for

internal consistency; and in the last sentence of section 10, "facility" was changed to "health care facility" for consistency.

PH *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

There is no fiscal impact to the Department of Public Health from various changes to statutes associated with its Office of Health Care Access.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

sHB 5321

AN ACT CONCERNING THE OFFICE OF HEALTH CARE ACCESS AND NOTICE BY HEALTH CARE FACILITIES REGARDING CONTRACTS FOR SERVICES.

SUMMARY:

This bill makes several changes to the statutes governing the Department of Public Health's (DPH) Office of Health Care Access (OHCA). It:

1. requires OHCA, when evaluating a certificate of need (CON) application, to consider its financial feasibility for the applicant instead of its impact on the financial strength of the state's healthcare system (§ 1);

2. requires OHCA to issue a decision on a completed CON application within 60 days after closing the public hearing record instead of after the public hearing date (§ 2);

3. requires short-term acute-care general hospitals and children's hospitals to submit quarterly operational and utilization data to OHCA by the last day of January, April, July, and October (§ 3);

4. extends from February 28 to March 31 the date by which a hospital must annually file certain information with OCHA regarding uncompensated care to the indigent (§§ 4 & 8);

5. requires OCHA to update its state-wide health care facilities and services plan biennially rather than every five years (§ 6);

6. requires OCHA to conduct its statewide health care facility utilization study biennially rather than annually (§ 6);

7. removes OHCA's authority to require a hospital's independent auditor to review discounted rates and charges it negotiated with a payer (§ 7);

8. allows OHCA to release patient-identifiable data to certain governmental entities for specified purposes (§ 9); and

9. establishes notification requirements for certain health care facilities that contract out for the provision of health care services (§ 10).

The bill makes technical and conforming changes and deletes obsolete provisions in §§ 5 and 7.

EFFECTIVE DATE: October 1, 2012

§ 10 — NOTIFICATION REQUIREMENTS FOR FACILITIES CONTRACTING OUT FOR HEALTH CARE SERVICES

The bill establishes notification requirements for certain health care facilities that contract out for the provision of "health care services" (the bill does not define this term). It applies to any facility that contracts with a corporation, limited liability company, organization, partnership, firm, or association licensed or certified by the state to provide health care services.

Within three business days after entering into the contract or 21 business days before it takes effect, whichever is later, the health care facility must (1) notify the DPH commissioner in writing of its intended or actual contract and (2) publish notice of its intended or actual contract in a conspicuous place on its website. The notice must include a description of the services that will be provided under the contract. The notice requirements do not apply to a contract between a health care facility and a licensed health care professional who works as an independent contractor at the facility.

Under the bill, "health care facility" means a DPH-licensed hospital; specialty hospital; freestanding emergency department; licensed outpatient surgical facility; state hospital, institution, or facility serving

public assistance beneficiaries; central service facility; mental health and substance abuse treatment facility; or any other facility requiring a CON. It includes a facility's parent company, subsidiary, affiliate, or joint venture.

§ 9 — RELEASE OF PATIENT-IDENTIFIABLE DATA

By law, patient-identifiable data OHCA receives must be kept confidential and is not considered a public record or file subject to disclosure under the Freedom of Information Act. Under current law, OHCA cannot release patient-identifiable data except (1) for medical and scientific research purposes as provided by law (CGS § 19a-25) and regulations and (2) to the comptroller pursuant to a memorandum of understanding that requires him to keep it confidential.

The bill also allows OHCA to release patient-identifiable data it receives to (1) a state agency for the purpose of improving health care service delivery, (2) a federal agency or the attorney general's office to investigate hospital mergers and acquisitions, or (3) another state's health data collection agency with which OHCA has a reciprocal data sharing agreement for reviewing a CON or evaluating health care services.

The bill allows the release of this data only if the agency (1) requests it and (2) enters into a written agreement with OHCA to keep the data confidential and not use it as the basis of any decision about a patient. The law prohibits the recipient of patient-identifiable data from releasing it in any manner that would result in the identification of any individual patient, physician, provider, or payer.

The law defines "patient identifiable data" as any information that identifies, or may reasonably be used as a basis to identify, an individual patient, including data from patient medical abstracts and bills.

§ 7 — NEGOTIATED DISCOUNTS

The law permits hospitals to negotiate agreements for rate discounts and reimbursement methods with insurers, HMOs, and other payers.

These agreements are not effective until they are filed at the hospital's business office and must be available for OHCA inspection. The hospital must total each payer's charges and payments and report it as OHCA requires. The bill removes OHCA's authority to require the hospital's independent auditor to review these figures, at the hospital's expense.

The bill also deletes an obsolete provision requiring OHCA to disallow an agreement that gives a discount in excess of amounts set in law and to adopt associated regulations. (OHCA has not regulated these discounts since 1994.)

§§ 4 & 8 — UNCOMPENSATED CARE REPORTING

By law, OHCA and the Department of Social Services must annually review the level of uncompensated care each hospital provides to indigent people. Hospitals must file with OHCA (1) audited financial statements and (2) a verification of their net revenue for the most recently completed fiscal year. The bill extends the filing deadline for the latter from February 28 to March 31. The deadline for the former remains March 31.

§ 6 — STATEWIDE HEALTH CARE FACILITY UTILIZATION STUDY

The bill requires OHCA to conduct its statewide health care facility utilization study and report its findings to the Human Services and Public Health committees biennially rather than annually. It also suggests, rather than requires, that the study assess:

1. the current availability and use of care in acute care and specialty hospitals, emergency rooms, outpatient surgical centers, clinics, and primary facilities;

2. the geographic areas and subpopulations that may be underserved or have limited access to specific types of services; and

3. other factors OHCA deems pertinent.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 18 Nay 10 (03/29/2012)